APPENDIX 12
WMAP COVERED DRUGS

A. COVERED DRUGS - LEGEND DRUGS

The WMAP uses an Open Formulary for legend drugs with few restrictions. Restrictions include:
Drugs Which Require Prior Authorization (See Sections C and D below), Noncovered Manufacturer Drugs (see Section A of Appendix 29 of this handbook), Less-Than-Effective Drugs (See Section B of Appendix 29 of this handbook) and Negative Formulary Drugs (See Section C of Appendix 29 of this handbook).

B. COVERED DRUGS - OVER-THE-COUNTER DRUGS

WMAP covered over-the-counter drugs are limited to ONLY the following categories:

ANALGESICS-ORAL/RECTAL[1]	COUGH SYRUPS[2]	INSULIN
ANTACIDS	FERROUS GLUCONATE/SULFATE FOR PREGNANT WOMEN	OPHTHALMIC LUBRICANTS
CONTRACEPTIVE SUPPLIES		

(*NOTE:* Coverage is limited to generic drugs for all covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are NOT covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Mylanta, Rolaids, Clear Tears, Lyteers, Neo Tears, Maalox, Titralac, Ecotrin, Robitussin, Tylenol, Ascriptin, Riopan and Advil.)

C. COVERED NON REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs require prior authorization because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to the WMAP which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement.

Generic equivalents of these drugs are not included in this requirement and may be billed without prior authorization if the generic manufacturer has signed a rebate agreement.

DALMANE	LIBRIUM	QUARZAN	TRANS-PLANTAR
EIGHT MOP	MELANEX	RIMSO 50	VALIUM
LIBRITABS	MENRIUM	TRANS-VER-SAL	

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1 Limited to single entity aspirin, acetaminophen, ibuprofen products only.

2 Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs are produced by manufacturers which have signed rebate agreements but require prior authorization to determine medical necessity. Diagnosis and information regarding the medical requirements for these drugs must be provided on the prior authorization request.

CS III & IV STIMULANTS
(Excludes Mazindol)
Benzphetamine
Diethylpropion
Fenfluramine
Phendimetrazine
Phentermine

ENTERAL NUTRITIONALS
Ensure, Pediasure
Meritine, Enrich
Sustacal, etc.

EPOETIN ALFA
Epogen, Procrit

LACTULOSE
Cephulac, Chronulac
Enulose, etc.

HUMAN GROWTH HORMONE
Humatrope
Protropin

CLOZAPINE
Clozaril

HYPERALIMENTATION
Total Parenteral Nutrition
Peripheral Parenteral Nutrition

UNLISTED/ INVESTIGATIONAL DRUGS
Biopterin (tetrahydrobiopterin)
Somogard (deslorelin)

ALPHA-1-PROTEINASE INHIBITOR
Prolastin

MUROMONAB-CD3
Orthoclone OKT3

INTERFERON
Alferon N, Intron-A
Roferon-A

DIPYRIDAMOLE (07/01/92)
Persantine

ALGLUCERASE (11/1/92)
Ceredase

TICLOPIDINE (11/1/92)
Ticlid